BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
LLORENS JOSEPH PEMBROOK, M.D.	)	**Case No. 800-2013-000193**
Physician's and Surgeon's Certificate No. A 37585	)	
Respondent	)	

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on September 15, 2017.

IT IS SO ORDERED: August 17, 2017.

MEDICAL BOARD OF CALIFORNIA

Michelle Anne Bholat MD

Michelle Anne Bholat, M.D., Chair
Panel B

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: LLORENS JOSEPH PEMBROOK, M.D. 4601 Coldwater Canyon, Suite 308 Los Angeles, California 91604 Physician's and Surgeon's Certificate No. A37585, Respondent.	Case No. 800-2013-000193 OAH No. 2016100747 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

In the interest of a prompt and speedy settlement of this matter, consistent with the public interest and the responsibility of the Medical Board of California (Board) of the Department of Consumer Affairs, the parties hereby agree to the following Stipulated Settlement and Disciplinary Order which will be submitted to the Board for approval and adoption as the final disposition of the Accusation.

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Board. She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Chris Leong, Deputy Attorney General.

2. Respondent Llorens Joseph Pembrook, M.D. (Respondent) is represented in this proceeding by attorney Raymond J. McMahon, whose address is: 100 Spectrum Center Drive, Suite 520, Irvine, CA 92618.

3. On or about March 9, 2005, the Board issued Physician's and Surgeon's Certificate No. A37585 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2013-000193, and will expire on July 31, 2017, unless renewed.

JURISDICTION

4. Accusation No. 800-2013-000193 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on April 19, 2016. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2013-000193 is attached as Exhibit A and is incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2013-000193. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2013-000193, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

12. Respondent agrees that if he ever petitions for early termination of probation or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in Accusation No. 800-2013-000193, shall be deemed true, correct and fully admitted by Respondent for purpose of that proceeding or any other licensing proceeding involving Respondent in the State of California.

CONTINGENCY

13. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

14. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

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15. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A37585 issued to Respondent Llorens Joseph Pembrook, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for seven (7) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES- MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all the following: 1) the name and address of patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

2. ALCOHOL - ABSTAIN FROM USE. Respondent shall abstain completely from the use of products or beverages containing alcohol.

3. CONTROLLED SUBSTANCES - ABSTAIN FROM USE. Respondent shall abstain completely from the personal use or possession of controlled substances as defined in the California Uniform Controlled Substances Act, dangerous drugs as defined by Business and Professions Code section 4022, and any drugs requiring a prescription. This prohibition does not apply to medications lawfully prescribed to Respondent by another practitioner for a bona fide illness or condition.

Within 15 calendar days of receiving any lawfully prescribed medications, Respondent

shall notify the Board or its designee of the: issuing practitioner's name, address, and telephone number; medication name, strength, and quantity; and issuing pharmacy name, address, and telephone number.

4. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

5. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its

designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

6. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

7. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in

addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

8. CLINICAL COMPETENCE ASSESSMENT. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of respondent's physical and mental health; and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision, Accusation, and any other information that the Board or its designee deems relevant. The program shall require respondent's on-site participation for a minimum of 3 and no more than 5 days as determined by the program for the assessment and clinical evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the respondent has demonstrated the ability to practice safely and independently. Based on respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical

condition, or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

9. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed

statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's

expense during the term of probation.

10. CLINICAL DIAGNOSTIC EVALUATIONS AND REPORTS: Within thirty (30) calendar days of the effective date of this Decision, and on whatever periodic basis thereafter as may be required by the Board or its designee, respondent shall undergo and complete a clinical diagnostic evaluation, including any and all testing deemed necessary, by a Board-appointed board certified physician and surgeon. The examiner shall consider any information provided by the Board or its designee and any other information he or she deems relevant, and shall furnish a written evaluation report to the Board or its designee.

The clinical diagnostic evaluation shall be conducted by a licensed physician and surgeon who holds a valid, unrestricted license, has three (3) years' experience in providing evaluations of physicians and surgeons with substance abuse disorders, and is approved by the Board or its designee. The clinical diagnostic evaluation shall be conducted in accordance with acceptable professional standards for conducting substance abuse clinical diagnostic evaluations. The evaluator shall not have a current or former financial, personal, or business relationship with respondent within the last five (5) years. The evaluator shall provide an objective, unbiased, and independent evaluation. The clinical diagnostic evaluation report shall set forth, in the evaluator's opinion, whether respondent has a substance abuse problem, whether respondent is a threat to himself or herself or others, and recommendations for substance abuse treatment, practice restrictions, or other recommendations related to respondent's rehabilitation and ability to practice safely. If the evaluator determines during the evaluation process that respondent is a threat to himself or herself or others, the evaluator shall notify the Board within twenty-four (24) hours of such a determination.

In formulating his or her opinion as to whether respondent is safe to return to either part-time or full-time practice and what restrictions or recommendations should be imposed, including participation in an inpatient or outpatient treatment program, the evaluator shall consider the following factors: respondent's license type; respondent's history; respondent's documented length of sobriety (i.e., length of time that has elapsed since respondent's last substance use); respondent's scope and pattern of substance abuse; respondent's treatment history, medical

history and current medical condition; the nature, duration and severity of respondent's substance abuse problem or problems; and whether respondent is a threat to himself or herself or the public.

For all clinical diagnostic evaluations, a final written report shall be provided to the Board no later than ten (10) days from the date the evaluator is assigned the matter. If the evaluator requests additional information or time to complete the evaluation and report, an extension may be granted, but shall not exceed thirty (30) days from the date the evaluator was originally assigned the matter.

The Board shall review the clinical diagnostic evaluation report within five (5) business days of receipt to determine whether respondent is safe to return to either part-time or full-time practice and what restrictions or recommendations shall be imposed on respondent based on the recommendations made by the evaluator. Respondent shall not be returned to practice until he or she has at least thirty (30) days of negative biological fluid tests or biological fluid tests indicating that he or she has not used, consumed, ingested, or administered to himself or herself a prohibited substance, as defined in section 1361.51, subdivision (e), of Title 16 of the California Code of Regulations.

Clinical diagnostic evaluations conducted prior to the effective date of this Decision shall not be accepted towards the fulfillment of this requirement. The cost of the clinical diagnostic evaluation, including any and all testing deemed necessary by the examiner, the Board or its designee, shall be borne by the licensee.

Respondent shall not engage in the practice of medicine until notified by the Board or its designee that he or she is fit to practice medicine safely. The period of time that respondent is not practicing medicine shall not be counted toward completion of the term of probation. Respondent shall undergo biological fluid testing as required in this Decision at least two (2) times per week while awaiting the notification from the Board if he or she is fit to practice medicine safely.

Respondent shall comply with all restrictions or conditions recommended by the examiner conducting the clinical diagnostic evaluation within fifteen (15) calendar days after being notified by the Board or its designee.

11. NOTICE OF EMPLOYER OR SUPERVISOR INFORMATION. Within seven (7)

days of the effective date of this Decision, respondent shall provide to the Board the names, physical addresses, mailing addresses, and telephone numbers of any and all employers and supervisors. Respondent shall also provide specific, written consent for the Board, respondent's worksite monitor, and respondent's employers and supervisors to communicate regarding respondent's work status, performance, and monitoring.

For purposes of this section, "supervisors" shall include the Chief of Staff and Health or Well Being Committee Chair, or equivalent, if applicable, when the respondent has medical staff privileges. If the clinical diagnostic evaluation does not reveal a substance abuse problem, this term is eliminated.

12. BIOLOGICAL FLUID TESTING. Respondent shall immediately submit to biological fluid testing, at respondent's expense, upon request of the Board or its designee. "Biological fluid testing" may include, but is not limited to, urine, blood, breathalyzer, hair follicle testing, or similar drug screening approved by the Board or its designee. Respondent shall make daily contact with the Board or its designee to determine whether biological fluid testing is required. Respondent shall be tested on the date of the notification as directed by the Board or its designee. The Board may order a respondent to undergo a biological fluid test on any day, at any time, including weekends and holidays. Except when testing on a specific date as ordered by the Board or its designee, the scheduling of biological fluid testing shall be done on a random basis. The cost of biological fluid testing shall be borne by the respondent.

During the first year of probation, respondent shall be subject to 52 to 104 random tests. During the second year of probation and for the duration of the probationary term, up to five (5) years, respondent shall be subject to 36 to 104 random tests per year. Only if there has been no positive biological fluid tests in the previous five (5) consecutive years of probation, may testing be reduced to one (1) time per month. Nothing precludes the Board from increasing the number of random tests to the first-year level of frequency for any reason.

Prior to practicing medicine, respondent shall contract with a laboratory or service, approved in advance by the Board or its designee, that will conduct random, unannounced, observed, biological fluid testing and meets all the following standards:

(a) Its specimen collectors are either certified by the Drug and Alcohol Testing Industry Association or have completed the training required to serve as a collector for the United States Department of Transportation.

(b) Its specimen collectors conform to the current United States Department of Transportation Specimen Collection Guidelines

(c) Its testing locations comply with the Urine Specimen Collection Guidelines published by the United States Department of Transportation without regard to the type of test administered.

(d) Its specimen collectors observe the collection of testing specimens.

(e) Its laboratories are certified and accredited by the United States Department of Health and Human Services.

(f) Its testing locations shall submit a specimen to a laboratory within one (1) business day of receipt and all specimens collected shall be handled pursuant to chain of custody procedures. The laboratory shall process and analyze the specimens and provide legally defensible test results to the Board within seven (7) business days of receipt of the specimen. The Board will be notified of non-negative results within one (1) business day and will be notified of negative test results within seven (7) business days.

(g) Its testing locations possess all the materials, equipment, and technical expertise necessary in order to test respondent on any day of the week.

(h) Its testing locations are able to scientifically test for urine, blood, and hair specimens for the detection of alcohol and illegal and controlled substances.

(i) It maintains testing sites located throughout California.

(j) It maintains an automated 24-hour toll-free telephone system and/or a secure on-line computer database that allows the respondent to check in daily for testing.

(k) It maintains a secure, HIPAA-compliant website or computer system that allows staff access to drug test results and compliance reporting information that is available 24 hours a day.

(l) It employs or contracts with toxicologists that are licensed physicians and have

knowledge of substance abuse disorders and the appropriate medical training to interpret and evaluate laboratory biological fluid test results, medical histories, and any other information relevant to biomedical information.

(m) It will not consider a toxicology screen to be negative if a positive result is obtained while practicing, even if the respondent holds a valid prescription for the substance.

Prior to changing testing locations for any reason, including during vacation or other travel, alternative testing locations must be approved by the Board and meet the requirements above.

The contract shall require that the laboratory directly notify the Board or its designee of non-negative results within one (1) business day and negative test results within seven (7) business days of the results becoming available. Respondent shall maintain this laboratory or service contract during the period of probation.

A certified copy of any laboratory test result may be received in evidence in any proceedings between the Board and respondent.

If a biological fluid test result indicates respondent has used, consumed, ingested, or administered to himself or herself a prohibited substance, the Board shall order respondent to cease practice and instruct respondent to leave any place of work where respondent is practicing medicine or providing medical services. The Board shall immediately notify all of respondent's employers, supervisors and work monitors, if any, that respondent may not practice medicine or provide medical services while the cease-practice order is in effect.

A biological fluid test will not be considered negative if a positive result is obtained while practicing, even if the practitioner holds a valid prescription for the substance. If no prohibited substance use exists, the Board shall lift the cease-practice order within one (1) business day.

After the issuance of a cease-practice order, the Board shall determine whether the positive biological fluid test is in fact evidence of prohibited substance use by consulting with the specimen collector and the laboratory, communicating with the licensee, his or her treating physician(s), other health care provider, or group facilitator, as applicable.

For purposes of this condition, the terms "biological fluid testing" and "testing" mean the acquisition and chemical analysis of a respondent's urine, blood, breath, or hair.

For purposes of this condition, the term "prohibited substance" means an illegal drug, a lawful drug not prescribed or ordered by an appropriately licensed health care provider for use by respondent and approved by the Board, alcohol, or any other substance the respondent has been instructed by the Board not to use, consume, ingest, or administer to himself or herself.

If the Board confirms that a positive biological fluid test is evidence of use of a prohibited substance, respondent has committed a major violation, as defined in section 1361.52(a), and the Board shall impose any or all of the consequences set forth in section 1361.52(b), in addition to any other terms or conditions the Board determines are necessary for public protection or to enhance respondent's rehabilitation.

13. SUBSTANCE ABUSE SUPPORT GROUP MEETINGS. Within thirty (30) days of the effective date of this Decision, respondent shall submit to the Board or its designee, for its prior approval, the name of a substance abuse support group which he or she shall attend for the duration of probation. Respondent shall attend substance abuse support group meetings at least once per week, or as ordered by the Board or its designee. Respondent shall pay all substance abuse support group meeting costs.

The facilitator of the substance abuse support group meeting shall have a minimum of three (3) years experience in the treatment and rehabilitation of substance abuse, and shall be licensed or certified by the state or nationally certified organizations. The facilitator shall not have a current or former financial, personal, or business relationship with respondent within the last five (5) years. Respondent's previous participation in a substance abuse group support meeting led by the same facilitator does not constitute a prohibited current or former financial, personal, or business relationship.

The facilitator shall provide a signed document to the Board or its designee showing respondent's name, the group name, the date and location of the meeting, respondent's attendance, and respondent's level of participation and progress. The facilitator shall report any unexcused absence by respondent from any substance abuse support group meeting to the Board, or its designee, within twenty-four (24) hours of the unexcused absence. If the clinical diagnostic evaluation does not reveal a substance abuse problem, this term is eliminated.

14. WORKSITE MONITOR FOR SUBSTANCE-ABUSING LICENSEE. Within thirty (30) calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as a worksite monitor, the name and qualifications of one or more licensed physician and surgeon, other licensed health care professional if no physician and surgeon is available, or, as approved by the Board or its designee, a person in a position of authority who is capable of monitoring the respondent at work.

The worksite monitor shall not have a current or former financial, personal, or familial relationship with respondent, or any other relationship that could reasonably be expected to compromise the ability of the monitor to render impartial and unbiased reports to the Board or its designee. . If it is impractical for anyone but respondent's employer to serve as the worksite monitor, this requirement may be waived by the Board or its designee, however, under no circumstances shall respondent's worksite monitor be an employee or supervisee of the licensee.

The worksite monitor shall have an active unrestricted license with no disciplinary action within the last five (5) years, and shall sign an affirmation that he or she has reviewed the terms and conditions of respondent's disciplinary order and agrees to monitor respondent as set forth by the Board or its designee.

Respondent shall pay all worksite monitoring costs.

The worksite monitor shall have face-to-face contact with respondent in the work environment on as frequent a basis as determined by the Board or its designee, but not less than once per week; interview other staff in the office regarding respondent's behavior, if requested by the Board or its designee; and review respondent's work attendance.

The worksite monitor shall verbally report any suspected substance abuse to the Board and respondent's employer or supervisor within one (1) business day of occurrence. If the suspected substance abuse does not occur during the Board's normal business hours, the verbal report shall be made to the Board or its designee within one (1) hour of the next business day. A written report that includes the date, time, and location of the suspected abuse; respondent's actions; and any other information deemed important by the worksite monitor shall be submitted to the Board or its designee within 48 hours of the occurrence.

The worksite monitor shall complete and submit a written report monthly or as directed by the Board or its designee which shall include the following: (1) respondent's name and Physician's and Surgeon's Certificate number; (2) the worksite monitor's name and signature; (3) the worksite monitor's license number, if applicable; (4) the location or location(s) of the worksite; (5) the dates respondent had face-to-face contact with the worksite monitor; (6) the names of worksite staff interviewed, if applicable; (7) a report of respondent's work attendance; (8) any change in respondent's behavior and/or personal habits; and (9) any indicators that can lead to suspected substance abuse by respondent. Respondent shall complete any required consent forms and execute agreements with the approved worksite monitor and the Board, or its designee, authorizing the Board, or its designee, and worksite monitor to exchange information.

If the worksite monitor resigns or is no longer available, respondent shall, within five (5) calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within fifteen (15) calendar days. If respondent fails to obtain approval of a replacement monitor within sixty (60) calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility. If the clinical diagnostic evaluation does not reveal a substance abuse problem, this term is eliminated.

15. VIOLATION OF PROBATION CONDITION FOR SUBSTANCE ABUSING LICENSEES. Failure to fully comply with any term or condition of probation is a violation of probation.

A. If respondent commits a major violation of probation as defined by section 1361.52, subdivision (a), of Title 16 of the California Code of Regulations, the Board shall take one or more of the following actions:

(1) Issue an immediate cease-practice order and order respondent to undergo a clinical diagnostic evaluation to be conducted in accordance with section 1361.5, subdivision (c)(1), of

Title 16 of the California Code of Regulations, at respondent's expense. The cease-practice order issued by the Board or its designee shall state that respondent must test negative for at least a month of continuous biological fluid testing before being allowed to resume practice. For purposes of the determining the length of time a respondent must test negative while undergoing continuous biological fluid testing following issuance of a cease-practice order, a month is defined as thirty calendar (30) days. Respondent may not resume the practice of medicine until notified in writing by the Board or its designee that he or she may do so.

(2) Increase the frequency of biological fluid testing.

(3) Refer respondent for further disciplinary action, such as suspension, revocation, or other action as determined by the Board or its designee.

B. If respondent commits a minor violation of probation as defined by section 1361.52, subdivision (c), of Title 16 of the California Code of Regulations, the Board shall take one or more of the following actions:

(1) Issue a cease-practice order;

(2) Order practice limitations;

(3) Order or increase supervision of respondent;

(4) Order increased documentation;

(5) Issue a citation and fine, or a warning letter;

(6) Order respondent to undergo a clinical diagnostic evaluation to be conducted in accordance with section 1361.5, subdivision (c)(1), of Title 16 of the California Code of Regulations, at respondent's expense;

(7) Take any other action as determined by the Board or its designee.

C. Nothing in this Decision shall be considered a limitation on the Board's authority to revoke respondent's probation if he or she has violated any term or condition of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter

is final, and the period of probation shall be extended until the matter is final.

16. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

17. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

18. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

19. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's place of residence. Respondent may engage in the practice of medicine in patient's place of residence. However, records must be maintained in an office.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

20. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

21. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice, including a cease practice order, shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

22. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

23. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

24. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its

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designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

25. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Raymond J. McMahon. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 4/11/17

LLORENS JOSEPH PEMBROOK, M.D.
Respondent

I have read and fully discussed with Respondent, Llorens Joseph Pembrook, M.D., the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 4/14/17

RAYMOND J. MCMAHON
Attorney for Respondent

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ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: 4/17/17

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

CHRIS LEONG
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2013-000193

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **LLORENS JOSEPH PEMBROOK, M.D.,** 4601 Coldwater Canyon, Suite 308 Studio City, California 91604 Physician's and Surgeon's Certificate No. A37585 Respondent.	Case No. 800-2013-000193 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant), brings this Accusation solely in her official capacity as Executive Director of the Medical Board of California (Board).

2. On or about October 19, 1981, the Board issued Physician's and Surgeon's Certificate No. A37585 to Llorens Joseph Pembrook, M.D. ("Respondent"). The Physician's and Surgeon's Certificate was in effect at all times relevant to the charges brought herein and, unless renewed, expires on July 31, 2017.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following sections of the Business and Professions Code (Code), Government Code, and Health and Safety Code.

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

"(f) Approving undergraduate and graduate medical education programs.

"(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

"(h) Issuing licenses and certificates under the board's jurisdiction.

"(i) Administering the board's continuing medical education program."

5. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

6. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the

standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

7. Section 2242 of the Code, states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

"(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

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"(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

"(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

"(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

8. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

9. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

10. Section 2241 of the Code states:

"(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

"(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

"(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

"(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

"(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

"(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

"(d) (1) For purposes of this section and Section 2241.5, "addict" means a person whose actions are characterized by craving in combination with one or more of the following:

"(A) Impaired control over drug use.

"(B) Compulsive use.

"(C) Continued use despite harm.

"(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5."

11. Section 2241.5 of the Code states:

"(a) A physician and surgeon may prescribe for, or dispense or administer to, a person under his or her treatment for a medical condition dangerous drugs or prescription controlled substances for the treatment of pain or a condition causing pain, including, but not limited to, intractable pain.

"(b) No physician and surgeon shall be subject to disciplinary action for prescribing, dispensing, or administering dangerous drugs or prescription controlled substances in accordance with this section.

"(c) This section shall not affect the power of the board to take any action described in Section 2227 against a physician and surgeon who does any of the following:

"(1) Violates subdivision (b), (c), or (d) of Section 2234 regarding gross negligence, repeated negligent acts, or incompetence.

"(2) Violates Section 2241 regarding treatment of an addict.

"(3) Violates Section 2242 or 2525.3 regarding performing an appropriate prior examination and the existence of a medical indication for prescribing, dispensing, or furnishing dangerous drugs or recommending medical cannabis.

"(4) Violates Section 2242.1 regarding prescribing on the Internet.

"(5) Fails to keep complete and accurate records of purchases and disposals of substances listed in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) or controlled substances scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. §§ 801, et seq.), or pursuant to the federal Comprehensive Drug Abuse Prevention and Control Act of 1970. A physician and surgeon shall keep records of his or her purchases and disposals of these controlled substances or dangerous drugs, including the date of purchase, the date and records of the sale or disposal of the drugs by the physician and surgeon, the name and address of the person receiving the drugs, and the reason for the disposal or the dispensing of the drugs to the person, and shall otherwise comply with all state recordkeeping requirements for controlled substances.

"(6) Writes false or fictitious prescriptions for controlled substances listed in the California

Uniform Controlled Substances Act or scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970.

"(7) Prescribes, administers, or dispenses in violation of this chapter, or in violation of Chapter 4 (commencing with Section 11150) or Chapter 5 (commencing with Section 11210) of Division 10 of the Health and Safety Code.

"(d) A physician and surgeon shall exercise reasonable care in determining whether a particular patient or condition, or the complexity of a patient's treatment, including, but not limited to, a current or recent pattern of drug abuse, requires consultation with, or referral to, a more qualified specialist.

"(e) Nothing in this section shall prohibit the governing body of a hospital from taking disciplinary actions against a physician and surgeon pursuant to Sections 809.05, 809.4, and 809.5."

12. Health and Safety Code section 11170 states:

"No person shall prescribe, administer, or furnish a controlled substance for himself."

13. Section 2239 of the Code states:

"(a) The use or prescribing for or administering to himself or herself, of any controlled substance; or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the licensee, or to any other person or to the public, or to the extent that such use impairs the ability of the licensee to practice medicine safely or more than one misdemeanor or any felony involving the use, consumption, or self-administration of any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct. The record of the conviction is conclusive evidence of such unprofessional conduct.

"(b) A plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this section. The Division of Medical Quality[1]

[1] Pursuant to Business and Professions Code section 2002, the "Division of Medical Quality" or "Division" shall be deemed to refer to the Medical Board of California.

may order discipline of the licensee in accordance with Section 2227 or the Division of Licensing may order the denial of the license when the time for appeal has elapsed or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code allowing such person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, complaint, information, or indictment."

INTRODUCTION

14. This Accusation involves prescriptions for medications regulated by the Comprehensive Drug Abuse Prevention and Control Act, passed into law in 1970. Title II of this law, the Controlled Substances Act, is the legal foundation of narcotics enforcement in the United States. The Controlled Substances Act regulates the manufacture, possession, movement, and distribution of drugs in our country. The Controlled Substances Act places all drugs into one of five schedules, or classifications, and is controlled by the Department of Justice and the Department of Health and Human Services, including the Federal Drug Administration. In 1972, California followed the federal lead by adopting the Uniform Controlled Substance Act. (Gov. Code, § 11153 et seq.)

15. The following delineates the five schedules with examples of drugs, medications, and information about each.

16. **Schedule I Drugs**

These drugs have NO safe, accepted medical use in the United States. This schedule includes drugs such as heroin, ecstasy, LSD, and crack cocaine. Schedule I drugs have a high tendency for abuse and have no accepted medical use. Pharmacies do not sell Schedule I drugs, and they are not available with a prescription by a physician.

17. **Schedule II Drugs**

Schedule II drugs have a high tendency for abuse, may have an accepted medical use, and can produce dependency or addiction with chronic use. Of all legal prescription medications, Schedule II controlled substances have the highest abuse potential. These drugs can cause severe

psychological or physical dependence. Schedule II drugs include certain narcotic, stimulant, and depressant drugs. Examples of Schedule II drugs include cocaine, opium, morphine, fentanyl, amphetamines, and methamphetamines.

Schedule II drugs may be available with a prescription by a physician, but not all pharmacies may carry them. These drugs require more stringent records and storage procedures than drugs in Schedules III and IV.

18. **Schedule III Drugs**

Schedule III drugs have less potential for abuse or addiction than drugs in the first two schedules and have a currently accepted medical use. The abuse of Schedule III drugs may lead to moderate to high psychological dependence.

Examples of Schedule III drugs include codeine, hydrocodone with acetaminophen, or anabolic steroids. Schedule III drugs may be available with a prescription, but not all pharmacies may carry them.

19. **Schedule IV Drugs**

Schedule IV drugs have a low potential for abuse that leads only to limited physical dependence or psychological dependence relative to drugs in Schedule III. Schedule IV drugs have a currently accepted medical use and have limited addictive properties. Schedule IV drugs have the same restrictions as Schedule III drugs.

Examples of Schedule IV drugs include Xanax, valium, phenobarbital, and Rohypnol (commonly known as the "date rape" drug). These drugs may be available with a prescription, but not all pharmacies may carry them.

20. **Schedule V Drugs**

Schedule V drugs have a lower chance of abuse than Schedule IV drugs, have a currently accepted medical use in the United States, and a lesser chance of dependence compared to Schedule IV drugs. This schedule includes such drugs as cough suppressants with codeine.

CONTROLLED SUBSTANCES AND DANGEROUS DRUGS

21. **Xanax** is a dangerous drug pursuant to Code section 4022. It is a Schedule IV Controlled Substance as designated by Health and Safety Code section 11057, subdivision

(d)(1). Its generic name is alprazolam and it is used to relieve anxiety.

22. **Norco**, a brand name for hydrocodone with acetaminophen, is a dangerous drug pursuant to Code section 4022. It is a Schedule II controlled substance as designated by Health and Safety Code section 10055, subdivision (b)(1)(I).

23. **Vicodin**, (Hydromorphone) is a dangerous drug pursuant to section 4022 of the Code. It is a Schedule III controlled substance, as designated by Health and Safety Code section 11056, subdivision (e)(4).

24. **Lorazepam** (Ativan) is a dangerous drug pursuant to section 4022 of the Code. It is a Schedule IV controlled substance, as designated by Health and Safety Code section 11057, subdivision (d)(16).

25. **Oxycontin** (oxycodone) is an opioid, i.e., a synthetic narcotic, that resembles the naturally occurring opiates. It is a Schedule II controlled substance, as designated by Health and Safety Code section 11055, subdivision (b)(1)(M),and a close relative of morphine, heroin, codeine, fentanyl, and methadone. It is a dangerous drug within the meaning of code section 4022.

26. **Hydrocodone/APAP** (Lortab) contains hydrocodone and acetaminophen. Acetaminophen, often abbreviated as APAP, is a peripherally acting analgesic agent found in many combination products and also available by itself. This combination product is used treat moderate to moderately severe pain. In the U.S., formulations containing more than 15 mg hydrocodone per dosage unit are considered Schedule II drugs. Those containing less than or equal to 15 mg per dosage unit in combination with acetaminophen or another non-controlled drug are called hydrocodone compounds and are considered Schedule III drugs. Hydrocodone is not available in pure form in the United States due to a separate regulation. Hydrocodone is always sold combined with another drug. It is also considered a dangerous drug under Code section 4022.

27. **Clonazepam (Klonopin)** is a dangerous drug pursuant to section 4022 of the Code. It is a Schedule IV controlled substance, as designated by Health and Safety Code section 11057, subdivision (d)(7). It is used in both the prophylaxis and treatment of various

seizure disorders. The dosage of Clonazepam should be carefully and slowly adjusted to meet the needs and requirements of the individual. An initial adult dose, however, should not exceed 1.5 mg daily. Adult maintenance dosage should generally not exceed 20 mg daily.

28. **AndroGel (Testosterone)** an anabolic steroid, is a Schedule III controlled substance pursuant to Health and Safety Code 11056, subdivision (f)(30), and a dangerous drug pursuant to Code section 4022.

29. **Dilaudid** (hydromorphone hydrochloride) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(K), and a dangerous drug within the meaning of Code section 4022. It is a narcotic analgesic used for pain.

30. **Diethylpropion** (generic for Tenuate) is a dangerous drug as specified in Code section 4022 and a Schedule IV controlled substance as defined in Health and Safety Code section 11057(f)(1).

31. **Demerol** (meperidine) is an opioid, i.e., a synthetic narcotic, that resembles the naturally occurring opiates. It is a Schedule II controlled substance, as designated by Health and Safety Code section 11055, and a close relative of morphine, heroin, codeine, fentanyl, and Methadone. It is a dangerous drug within the meaning of code section 4022.

32. **Alprazolam** is a dangerous drug as specified in Code section 4022 and a Schedule IV controlled substance as defined in Health and Safety Code section 11057(d)(1).

33. **Vicoprofen** contains hydrocodone and ibuprofen. This combination product is used on a short term basis to treat severe pain. In the U.S., formulations containing more than 15 mg hydrocodone per dosage unit are considered Schedule II drugs. Those containing less than or equal to 15 mg per dosage unit in combination with acetaminophen or another non-controlled drug are called hydrocodone compounds and are considered Schedule III drugs. Hydrocodone is not available in pure form in the United States due to a separate regulation. Hydrocodone is always sold combined with another drug. It is also considered a dangerous drug under Code section 4022.

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34. **Ambien (zolpidem)** is a dangerous drug pursuant to section 4022 of the Code. It is a Schedule IV controlled substance, as designated by Health and Safety Code section 11057, subdivision (d)(32). It is used to treat insomnia.

35. **Ultram** (tramadol) is a narcotic-like pain reliever.

36. **Provigil** (mondafinil)) is a dangerous drug pursuant to section 4022 of the Code. It is a Schedule IV controlled substance, as designated by Health and Safety Code section 11057, subdivision (f)(3). It is a medication that promotes wakefulness.

37. **Suboxone (Buprenorphine and Naloxone)** is a dangerous drug pursuant to Code section 4022. It is a Food and Drug Administration (FDA) Schedule C-III controlled substance pursuant to Code of Federal Regulations section 1308.13(e)(2)(i). It is used to relieve opioid dependence.

38. **Robaxin** is not a controlled substance. It is a skeletal muscle relaxant. It is a dangerous drug pursuant to Code section 4022 and therefore requires a prescription.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

39. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that he was grossly negligent in the care and treatment of his patients. The circumstances are as follows:

Patient L.P.[2] (Respondent)

40. The Board received an anonymous call that Respondent was drinking alcohol and taking Ultram and pain medications. The CURES report of Respondent's prescriptions show he prescribed himself multiple medications that are controlled substances. He prescribed himself these medications at two different pharmacies. The pharmacies were Riverside Discount Pharmacy and Michael's Pharmacy. The medications listed on the CURES report included alprazolam, hydromorphone, diazepam and AndroGel. In addition, per copies of

[2]The names of patients are kept confidential to protect their privacy rights, and, though known to Respondent, will be revealed to him upon receipt of a timely request for discovery.

prescription histories of Respondent from the above two pharmacies, he also prescribed himself AndroGel, Demerol, and Diethylpropion (Tenuate).

41. Respondent prescribed controlled medications to himself, including but not limited to, as follows:

Date	Drug		Quantity	Prescription No.
June 19, 2012	Demerol	100 mg/ml	-	279286
March 28, 2013	AndroGel	1.62%	-	279286
June 14, 2013	AndroGel	1.62%	-	279286 (refill)
June 28, 2013	AndroGel	1.62%	-	279286 (refill)
March 18, 2011	Diethylpropion	25 mg	50	506384
March 7, 2012	Diethylpropion	25 mg	30	506384
December 3, 2010	Diethylpropion	25 mg	25	506384
March 18, 2011	Diethylpropion	25 mg	50	506384 (refill)
March 7, 2012	Diethylpropion	25 mg	30	514690
June 17, 2011	Alprazolam	25 mg	30	213325
April 19, 2013	AndroGel	1.62%		279286 (refill)

Patient E.P.

42. Patient E.P. has never taken the drug Diethylpropion (Tenuate), never picked up the medication Tenuate from a pharmacy, and he has never been to Tarzana Pharmacy. Respondent's address is 4601 Coldwater Canyon #308, not #305. E.P. has never lived at either of those addresses. The last time Respondent prescribed medications to E.P. and performed physical exams on E.P. was about 2001. Respondent's certified medical records for E.P. is one page with four entries, one dated in 2010, another in 2012 and the two remaining in 2014. Respondent documents low dose Tenuate for weight increase. The documentation is inadequate. There is no documentation of the patient's medical history, medication reconciliation, allergies, and vital signs.

43. Respondent prescribed controlled medications to E.P. as follows:

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Date	Drug	Quantity	Prescription No.
March 9, 2012	Diethylpropion Hydrochloride	30	1016311

Patient R.L.

44. Respondent wrote several prescriptions for colleague Dr. R.L. They have known each other professionally for about 25 years. Dr. R.L. knew that Respondent was a hospice doctor and had the appropriate license to prescribe the Suboxone. Dr. R.L. gave Respondent a list of his medications. Dr. R.L. did not go to Respondent's office, because Respondent did not have one. One discussion they had regarding medications was in a parking lot. Dr. R.L. did not fill out any paperwork or medical questionnaire, because this was done verbally with Respondent. The components of a physical exam (taking vital signs, CT scans) were never performed after he started treating Dr. R.L. in April 2012. In addition, Respondent wrote prescriptions/renewals for Clonazepam, Vicoprofen, Ambien, Lorazepam, and Robaxin.

45. Respondent's medical records for Dr. R.L. were very spotty. One progress note dated September 2, 2012, for Dr. R.L. was in Respondent's records. It lacked vital signs, a medication list, a medical problem list, and documentation of a physical exam. Issues such as anxiety and depression should have been discussed but were not documented. There was no documentation regarding a pain scale, alleviating or exacerbating factors related to the pain, or non-pharmacological modalities for pain. There was no documentation related to the controlled substances prescribed.

46. Respondent prescribed controlled medications to R.L. including but not limited to as follows:

Date	Drug	Quantity	Prescription No.
April 1, 2013	Clonazepam .5 mg	30	C533.772
April 30, 2013	Suboxone	60	C534.730
May 8, 2013	Zolpidem tartrate 10 mg	30	C534.313
May 17, 2013	Ambien 10 mg	30	C535.265
June 24, 2013	Lorazepam 2 mg	60	C534.351
July 30, 2013	Lorazepam 2 mg	60	C537.373

August 12, 2013	Hydrocodone BIT	30	C534.421
October 4, 2013	Clonazepam .5 mg	30	C539.424
October 4, 2013	Ambien 12.5 mg	10	C539.425
November 7, 2013	Hydrocodone BIT	30	C540.563
November 7, 2013	Vicoprofen 200 mg	30	C540.563
November 14, 2012	Robaxin 750 mg	10	529476
November 18, 2013	Clonazepam .5 mg	30	C535.264
November 20, 2013	Buprenorphine –Naloxone (Suboxone)	30	C536.348

Patient A.L.

47. Respondent wrote several prescriptions for colleague and one time girlfriend Dr. A.L. Prescriptions were apparently for multiple medications for conditions such as hypertension, asthma and Diabetes. Some of the prescriptions are for controlled substances such as tramadol and Provigil. There exists only one page of documentation for Dr. A.L. On this one page there are four entry dates, two in 2012 and two in 2013. There is no physical examination, no listing of medical history, and no vital signs in the documentation. Respondent maintains that he took a verbal history which included a past and current medical history, social history, psychiatric history, and list of medications. He also maintained that he took her blood pressure, pulse, temperature, weight, examined her heart and lungs. However, this history and exams were not documented. Respondent prescribed multiple medications for Dr. A.L .

48. Respondent prescribed controlled medications to A.L. including but not limited to as follows:

Date	Drug	Quantity	Prescription No.
April 2, 2013	Provigil 200 mg	30	279664
August 28, 2013	Provigil 200 mg	30	292907 (four refills)
May 13, 2014	Tramadol HCL 50 mg	240	315412

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Patient G.S.

49. Respondent certified that there were no medical records for patient G.S. Respondent claims that he examined patient G.S. and had a discussion with her for about 25 - 30 minutes. Respondent wrote several prescriptions and six refills for Norco (Hydrocodone) for patient G.S.

50. Respondent prescribed controlled medications to G.S., including but not limited to, as follows:

Date	Drug	Quantity	Prescription No.
September 24, 2010	Norco10-325 mg	60	642135
February 2, 2011	Hydrocodone/APAP 10-325 mg	60	642135 (authorized five refills)
February 3, 2011	Hydrocodone/APAP 10-325 mg	60	647740
April 13, 2011	Hydrocodone/APAP 10-325 mg	60	647740
June 2, 2011	Hydrocodone/APAP 10-325 mg	60	647740
August 8, 2011	Hydrocodone/APAP 10-325 mg	60	661842 (authorized six refills)
September 15, 2011	Hydrocodone/APAP 10-325 mg	60	661842

Patient D.V.

51. Respondent wrote several prescriptions and refills for hydrocodone for patient D.V. Respondent certified that there were no medical records for patient D.V. from Respondent.

52. Respondent prescribed controlled medications to D.V., including but not limited to, as follows:

Date	Drug	Quantity	Prescription No.
March 2, 2011	Hydrocodone/Acetaminophen 7.5-750 mg	50	303145
March 8, 2011	Hydrocodone/Acetaminophen 7.5-750 mg	60	304962
March 18, 2011	Hydrocodone/Acetaminophen 7.5-750 mg	60	304962
March 30, 2011	Hydrocodone/Acetaminophen 7.5-750 mg	60	304962

April 22, 2011	Hydrocodone/Acetaminophen 7.5-750 mg	60	304962

Patient K.W.

53. Respondent wrote numerous prescriptions and authorized refills for patient K.W. over several years. Patient K.W. had a medical history of C2/C3 fracture with quadriplegia, spasticity, UTIs and pressure related wounds. It is noted that patient K.W. was being prescribed medications from multiple providers. Prescriptions include antibiotics, antivirals, supplements, muscle relaxants, topical medications and multiple controlled substances. Numerous documentation related to patient K.W. and his multiple complex medical issues were not face to face interviews and examinations with patient K.W., but telephone discussions with other physicians, patient K.W.'s sister and patient K.W. himself. Therefore, vital signs, and physical examination documentation are absent in these documents. Documentation related to home visits are inadequate due to lack of vital signs, comprehensive medical problem list and assessment and plan. Some of the documentation for patient K.W. only include the entry date, name and medication list.

54. Respondent prescribed controlled medications to K.W., including but not limited to, as follows:

Date	Drug	Quantity	Prescription No.
March 20, 2010	Oxycontin 80 mg	130	404703
May 28, 2010	Hydromorphone 8 mg	150	N0932674
July 10, 2010	Hydromorphone 8 mg	150	N0938276
August 22, 2010	Hydromorphone 8 mg	120	N0944127
November 8, 2010	Alprazolam 2 mg	37	0502377
February 12, 2011	Oxycontin 80 mg	150	428762
April 12, 2011	Oxycodone HCL 30 mg	180	432486
May 24, 2011	Oxycodone HCL 30 mg	180	435063
July 11, 2011	Alprazolam 2 mg	75	1301482
July 27, 2011	Alprazolam 2 mg	75	1301478
August 29, 2011	Xanax 2 mg	120	C0994481

September 21, 2011	Alprazolam 2 mg	30	1324463
November 6, 2011	Alprazolam 2 mg	30	1328786
June 17, 2012	Alprazolam 2 mg	30	1380716
June 19, 2012	Sulfamethoxazole 800 mg	7	1381336

Patient L.Z.

55. Patient L.Z. is a nurse and worked with Respondent from August 2009 to May 2012 at Tarzana Hospital. In June 2011, Respondent wrote a hydrocodone prescription for patient L.Z with three refills. The prescription was filled at Walgreens Pharmacy for Vicodin, 150 tablets. Respondent did not examine her in an office.

56. On March 2, 2015, Respondent certified that there were no medical records pertaining to patient L.Z. A one page document with two dated entries for patient L.Z. was discovered. With the two dated entries, the typed information includes a brief subjective, objective, assessment, and plan (SOAP) note for patient L.Z. The entry dated "April 2010" states that a one time refill for Vicodin was ordered and 90 tablets was dispensed. The entry dated "December 2011" states a refill of 100 tablets of Vicodin was given. Respondent signed both entries.

57. Respondent's conduct, as described above, constitutes gross negligence, in that Respondent committed errors and omissions in the care and treatment of patients. as follows:

A. Respondent prescribed controlled substances to himself without appropriate and necessary medical emergency or justification.

B. Respondent failed to have an appropriate examination and complete evaluation by an appropriate person/medical provider authorized to write prescriptions to him under California law.

C. Respondent failed to maintain adequate and accurate medical records regarding patient E.P.

D. Respondent prescribed Tenuate to patient E.P. without adequate documentation in the medical records of the appropriate dosages, monitoring, informed consent regarding potential side effects of the medications, alternative therapies tried and goals of the

controlled substance therapy. This medication has the potential for abuse and taking a detailed, complete history is required.

E. Respondent failed to maintain adequate and accurate medical records regarding patient R.L., including:

1. A plan for treatment of the pain such as objectives of pain treatment. Respondent did not document what the goal of pain treatment would be and if the goals had been met.

2. Respondent did not keep accurate and complete medical records related to the above. Medical record documentation related to pain management did not include the risks and benefits of the controlled substances, potential side effects and follow up reviews of the treatment plan.

3. Respondent failed to adequately document the appropriate dosages, monitoring, informed consent regarding potential side effects of the medications, alternative therapies tried and goals of the controlled substance. These medications have the potential for abuse and need to be carefully prescribed and monitored.

F. Respondent failed to follow the standard of care in managing pain for patient R.L. Respondent prescribed Suboxone and Vicoprofen without documentation regarding a substance abuse history, mental health evaluation, history of prior pain treatments, assessment of the pain and documentation of the presence of a recognized medical indication for the use of a controlled substance.

G. Respondent failed to maintain adequate and accurate medical records regarding patient A.L., including:

1. Respondent's one page documentation of Dr. A.L.'s medical history, examination assessment and plan are inadequate. Dr. A.L.'s past and current medical history, social history, psychiatric history and list of medications, physical exam, vital signs and assessment and plan are lacking in the documentation. It is unclear at times for what medical conditions Respondent was prescribing.

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2. Respondent prescribed Provigil which is a class IV scheduled substance. It is unclear from the records what it was being prescribed for. Respondent prescribed this controlled substance without adequate documentation in the medical records of the appropriate dosages, monitoring, informed consent regarding potential side effects of the medications, alternative therapies tried and goals of the controlled substance.

H. Respondent failed to follow the standard of care in managing pain patient A.L. Respondent prescribed Tramadol which is an opioid used to treat pain. Documentation regarding a substance abuse history, mental health evaluation, history of prior pain treatments, assessment of the pain and documentation of the presence of a recognized medical indication for the use of a controlled substance was absent. There was no documentation regarding a pain scale, alleviating or exacerbating factors related to the pain, or non-pharmalogical modalities for pain. There was absence of documentation related to:

1. A plan for treatment of the pain such as objectives of pain treatment. Respondent did not document what the goal of pain treatment would be and if the goals had been met.

2. The risks and benefits to the controlled substances, potential side effects and subsequent reviews of the treatment plan.

I. Respondent failed to maintain adequate and accurate medical records regarding patient G.S., including:

1. There are no medical records pertaining to patient G.S. There is no documentation regarding past and current medical history, social history, psychiatric history and list of medications, physical exam, vital signs and assessment and plan.

2. Respondent prescribed and authorized refills for patient G.S. of Norco, multiple times, without medical documentation. There is no documentation in the medical records of the appropriate dosages, monitoring, informed consent regarding potential side effects of the medication, alternative therapies tried and goals of the controlled substance.

J. Respondent failed to maintain adequate and accurate medical records regarding patient D.V., including:

1. Respondent failed to maintain any medical records pertaining to patient D.V. There is no documentation regarding patient D.V.'s past and current medical history, social history, psychiatric history and list of medications, physical exam, vital signs and assessment and plan.

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2. Respondent failed to maintain any documentation or medical records of the appropriate dosages, monitoring, informed consent regarding potential side effects of the medications, alternative therapies tried and goals of the controlled substance.

K. Respondent failed to maintain adequate and accurate medical records regarding patient K.W. Respondent failed to document the medical problems the medications were prescribed for. Documentation of patient K.W.'s medical history, examination assessment and plan are inadequate. Patient K.W.'s social history, psychiatric history and list of medications, physical exam, vital signs and assessment and plan are lacking in the documentation.

L. Respondent failed to follow the standard of care in managing pain patient K.W. Patient K.W. was prescribed multiple medications that can be used for pain. Respondent prescribed OxyContin, hydromorphone and oxycodone which are opioids used to treat pain. Documentation regarding a substance abuse history, mental health evaluation, history of prior pain treatments, assessment of the pain and documentation of the presence of a recognized medical indication for the use of a controlled substance was absent. There was no documentation regarding a pain scale, alleviating or exacerbating factors related to the pain, or non-pharmalogical modalities for pain. There was an absence of documentation related to:

1. A plan for treatment of the pain with objectives for the pain treatment. Respondent failed to document if the goals had been met.

2. Medical record documentation related to pain management did not include the risks and benefits to the controlled substances, potential side effects and reviews of the treatment plan.

M. Respondent failed to follow the standard of care in prescribing controlled substances to pain patient K.W. Respondent prescribed and authorized refills for multiple

controlled substances for patient K.W. which were filled at multiple pharmacies. Patient K.W. was prescribed and received refills numerous times, from Respondent and other physicians; medications that included Alprazolam (Schedule IV), hydromorphone (Schedule II), oxycodone (Schedule II) and OxyContin (Schedule II).

1. Respondent failed to adequately monitor patient K.W. when multiple providers were prescribing multiple controlled substances to a complex medical patient with quadriplegia. Indications and goals of therapies with controlled substances such as pain medications that patient K.W. was prescribed are needed to monitor for tolerance, abuse, addiction and side effects. Patient K.W. was on very large doses of these controlled substances and needed close face to face monitoring while on these medications. In addition to vital signs and routine lab testing, face to face examinations of potential side effects of the medications was needed. Since patient K.W. was on high doses of controlled substances, other causes of pain or other modalities to control pain needed to be assessed to prevent addiction and potential overdose of these medications.

2. Respondent failed to adequately monitor patient K.W. for illicit use and abuse. Providers need to be aware of "doctor shopping" and prescribing by multiple providers, especially with controlled substances. Therefore complete history taking involving a mental health evaluation, evaluation of prior history of substance abuse and documentation of diagnoses/conditions requiring the controlled substances is needed.

N.. Respondent failed to maintain adequate and accurate medical records regarding patient L.Z., including:

1. Respondent's one page medical record regarding patient L.Z. was inadequate. Respondent prescribed Vicodin. Respondent failed to adequately document past and current medical history, vital signs, list of current medications, physical examination, assessment and plan.

2. Respondent failed to maintain adequate documentation in the medical records of the appropriate dosages, monitoring, informed consent regarding potential side effects of the medications, alternative therapies tried and goals of the controlled substance.

O. Respondent failed to adequately manage pain patient L.Z's Vicodin, which is an opioid used to treat pain. Documentation regarding a substance abuse history, mental health evaluation, history of prior pain treatments, assessment of the pain and documentation of the presence of a recognized medical indication for the use of a controlled substance was absent. There was no documentation regarding a pain scale, alleviating or exacerbating factors related to the pain, or non-pharmacological modalities for pain. Medical record documentation related to pain management did not include the risks and benefits of the controlled substances, potential side effects and subsequent reviews of the treatment plan.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

58. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that he was repeatedly negligent in the care and treatment of his patients. The facts and circumstances alleged above in the First Cause for Discipline are incorporated here as if fully set forth and as follows:

A. Respondent prescribed controlled substances to himself without appropriate and necessary medical emergency or justification.

B. Respondent failed to have an appropriate examination and complete evaluation by an appropriate person/medical provider authorized to write prescriptions to him under California law.

C. Respondent failed to maintain adequate and accurate medical records regarding patient E.P.

D. Respondent prescribed Tenuate to patient E.P. without adequate documentation in the medical records of the appropriate dosages, monitoring, informed consent regarding potential side effects of the medications, alternative therapies tried and goals of the controlled substance therapy. This medication has the potential for abuse and taking a detailed, complete history is required.

E. Respondent failed to maintain adequate and accurate medical records regarding patient R.L., including:

1. A plan for treatment of the pain such as objectives of pain treatment. Respondent did not document what the goal of pain treatment would be and if the goals had been met.

2. Respondent did not keep accurate and complete medical records related to the above. Medical record documentation related to pain management did not include the risks and benefits of the controlled substances, potential side effects and follow up reviews of the treatment plan.

3. Respondent failed to adequately document the appropriate dosages, monitoring, informed consent regarding potential side effects of the medications, alternative therapies tried and goals of the controlled substance. These medications have the potential for abuse and need to be carefully prescribed and monitored.

F. Respondent failed to follow the standard of care in managing pain for patient R.L. Respondent prescribed Suboxone and Vicoprofen without documentation regarding a substance abuse history, mental health evaluation, history of prior pain treatments, assessment of the pain and documentation of the presence of a recognized medical indication for the use of a controlled substance.

G. Respondent failed to maintain adequate and accurate medical records regarding patient A.L., including:

1. Respondent's one page documentation of Dr. A.L.'s medical history, examination, assessment and plan are inadequate. Dr. A.L.'s past and current medical history, social history, psychiatric history, list of medications, physical exam, vital signs and assessment and plan are lacking in the documentation. It is unclear at times for what medical conditions Respondent was prescribing for.

2. Respondent prescribed Provigil which is a class IV scheduled substance. It is unclear from the records what it was being prescribed for. Respondent prescribed this controlled substance without adequate documentation in the medical records of the appropriate dosages, monitoring, informed consent regarding potential side effects of the medications, alternative therapies tried and goals of the controlled substance.

H. Respondent failed to follow the standard of care in managing pain patient A.L. Respondent prescribed Tramadol which is a opioid used to treat pain. Documentation regarding a substance abuse history, mental health evaluation, history of prior pain treatments, assessment of the pain and documentation of the presence of a recognized medical indication for the use of a controlled substance was absent. There was no documentation regarding a pain scale, alleviating or exacerbating factors related to the pain, or non-pharmalogical modalities for pain. There was absence of documentation related to:

1. A plan for treatment of the pain such as objectives of pain treatment. Respondent did not document what the goal of pain treatment would be and if the goals had been met.

2. The risks and benefits to the controlled substances, potential side effects and subsequent reviews of the treatment plan were never discussed.

I. Respondent failed to maintain adequate and accurate medical records regarding patient G.S., including:

1. There are no medical records pertaining to patient G.S. There is no documentation regarding past and current medical history, social history, psychiatric history and list of medications, physical exam, vital signs and assessment and plan.

2. Respondent prescribed and authorized refills for patient G.S. of Norco, multiple times, without medical documentation. There is no documentation in the medical records of the appropriate dosages, monitoring, informed consent regarding potential side effects of the medication, alternative therapies tried and goals of the controlled substance.

J. Respondent failed to maintain adequate and accurate medical records regarding patient D.V., including:

1. Respondent failed to maintain any medical records pertaining to patient D.V. There is no documentation regarding patient D.V.'s past and current medical history, social history, psychiatric history, list of medications, physical exam, vital signs and assessment and plan.

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2. Respondent failed to maintain any documentation or medical records of the appropriate dosages, monitoring, informed consent regarding potential side effects of the medications, alternative therapies tried and goals of the controlled substance.

K. Respondent failed to maintain adequate and accurate medical records regarding patient K.W. Respondent failed to document the medical problems the medications were prescribed for. Documentation of patient K.W.'s medical history, examination assessment and plan are inadequate. Patient K.W.'s social history, psychiatric history, list of medications, physical exam, vital signs and assessment and plan are lacking in the documentation.

L. Respondent failed to follow the standard of care in managing pain patient K.W. Patient K.W. was prescribed multiple medications that can be used for pain. Respondent prescribed OxyContin, hydromorphone and oxycodone which are opioids used to treat pain. Documentation regarding a substance abuse history, mental health evaluation, history of prior pain treatments, assessment of the pain and documentation of the presence of a recognized medical indication for the use of a controlled substance was absent. There was no documentation regarding a pain scale, alleviating or exacerbating factors related to the pain, non-pharmalogical modalities for pain. There was an absence of documentation related to:

1. A plan for treatment of the pain with objectives for the pain treatment. Respondent failed to document if the goals had been met.

2. Medical record documentation related to pain management did not include the risks and benefits of the controlled substances, potential side effects and reviews of the treatment plan.

M. Respondent failed to follow the standard of care in prescribing controlled substances to pain patient K.W. Respondent prescribed and authorized refills for multiple controlled substances for patient K.W. which were filled at multiple pharmacies. Patient K.W. was prescribed and received refills numerous times, from Respondent and other physicians; medications that included Alprazolam (Schedule IV), hydromorphone (Schedule II), oxycodone (Schedule II) and OxyContin (Schedule II).

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1. Respondent failed to adequately monitor patient K.W. when multiple providers were prescribing multiple controlled substances to a complex medical patient with quadriplegia. Indications and goals of therapies with controlled substances such as pain medications that patient K.W. was prescribed are needed to monitor for tolerance, abuse, addiction and side effects. Patient K.W. was on very large doses of these controlled substances and needed close face to face monitoring while on these medications. In addition to vital signs and routine lab testing, face to face examinations of potential side effects of the medications was needed. Since patient K.W. was on high doses of controlled substances, other causes of pain or other modalities to control pain needed to be assessed to prevent addiction and potential overdose of these medications.

2. Respondent failed to adequately monitor patient K.W. for illicit use and abuse. Providers need to be aware of "doctor shopping" and prescribing by multiple providers, especially with controlled substances. Therefore complete history taking involving a mental health evaluation, evaluation of prior history of substance abuse and documentation of diagnoses/conditions requiring the controlled substances is needed.

N.. Respondent failed to maintain adequate and accurate medical records regarding patient L.Z., including:

1. Respondent's one page medical record regarding patient L.Z. was inadequate. Respondent prescribed Vicodin. Respondent failed to adequately document past and current medical history, vital signs, list of current medications, physical examination, assessment and plan.

2. Respondent failed to maintain adequate documentation in the medical records of the appropriate dosages, monitoring, informed consent regarding potential side effects of the medications, alternative therapies tried and goals of the controlled substance.

O. Respondent failed to adequately manage pain patient L.Z's Vicodin, which is an opioid used to treat pain. Documentation regarding a substance abuse history, mental health evaluation, history of prior pain treatments, assessment of the pain and documentation of the presence of a recognized medical indication for the use of a controlled substance was absent.

There was no documentation regarding a pain scale, alleviating or exacerbating factors related to the pain, or non-pharmacological modalities for pain. Medical record documentation related to pain management did not include the risks and benefits of the controlled substances, potential side effects and subsequent reviews of the treatment plan.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

59. Respondent is subject to disciplinary action under Code section 2234, subdivision (d), in that he was incompetent in the care and treatment of Patients L.P., E.P., R.L., A.L., G.S., D.V., K.W., and L.Z. The facts and circumstances alleged above in the First Cause For Discipline are incorporated here as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

60. Respondent is subject to disciplinary action under Code section 2266, in that he failed to maintain adequate and accurate records relating to the provision of medical services to Patients L.P., E.P., R.L., A.L., G.S., D.V., K.W., and L.Z. The fact and circumstances alleged above in the First Cause For Discipline are incorporated here as if fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(Self-Prescribing)

61. Respondent is subject to disciplinary action under Code section 2239 and Health and Safety Code section 11170 in that he prescribed to himself controlled substances. . The facts and circumstances alleged above in the First Cause For Discipline are incorporated here as if fully set forth.

SIXTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

62. Respondent is subject to disciplinary action under Code section 725 in that he engaged in excessive treatment or prescribing in care and treatment of Patients L.P., E.P., R.L., A.L., G.S., D.V., K.W., and L.Z. The facts and circumstances alleged above in the First Cause For Discipline are incorporated here as if fully set forth.

SEVENTH CAUSE FOR DISCIPLINE

(Prescribing Controlled Substances Without a Physical Exam)

63. Respondent is subject to disciplinary action under Code section 2242 in that he prescribed controlled substances without a physical exam to Patients L.P., E.P., R.L., A.L., G.S., D.V., K.W., and L.Z. The facts and circumstances alleged above in the First Cause For Discipline are incorporated here as if fully set forth.

EIGHTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

64. Respondent is subject to disciplinary action under Code section 2234 in that he engaged in unprofessional conduct in care and treatment of Patients L.P., E.P., R.L., A.L., G.S., D.V., K.W., and L.Z. The facts and circumstances alleged above in paragraphs 39 through 64, are incorporated here as if fully set forth.

PRAYER

WHEREFORE, Complainant request that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A37585, issued to Llorens Joseph Pembrook, M.D.;

2. Revoking, suspending or denying approval of his authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering him to pay the Medical Board of California, if placed on probation, the cost of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: April 19, 2016

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California